Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Bodies in Balance

Respondent Name
TPCIGA for Lumbermens Mutual Co

MFDR Tracking Number
M4-14-2464-01

Carrier's Austin Representative Box
Box Number 50

MFDR Date Received
April 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Request for payment submitted on a timely manner eob's denial due to lack of preauthorization. Appeal submitted again, eob's faxed to our facility 12/02/14 with same statement no preauthorization obtain…."

Amount in Dispute: $21,042.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: TPCIGA would like to bring to the attention of the Division that the health care provider did not submit a formal request for reconsideration to TPCIGA as outlined in the Division of Workers Compensation rule 133.240(i)(j) & 133.250. It is our position that this is not a valid request for Medical Dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 3, 2013 through August 15, 2013	90791, 97750, 97799 CP	$21,042.00	$16,838.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out reimbursement guidelines for Workers Compensation specific services.
3. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services
4. The services in dispute were denied/reduced with the following reasons;
   - 185 – The rendering provider is not eligible to perform the service billed
   - 197 – Precertification/authorization/notification absent

Issues

1. Is the respondent's position statement supported?
2. Did the requestor support services received prior authorization?

3. What is applicable rule pertaining to chronic pain management
4. What is the applicable rule pertaining to the physician services?
5. Is the requestor entitled to reimbursement?

Findings

1. The carrier states, "TPCIGA would like to bring to the attention of the Division that the health care provider did not submit a formal request for reconsideration to TPCIGA as outlined in the Division of Workers Compensation rule 133.240(i)(j) & 133.250." Review of the finds a request for reconsideration from the requestor dated December 01, 2013. Therefore, the carrier's statement is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. Review of the submitted documentation finds two documents from Genex with the following information

    a. May 13, 2013 – Procedure(s): 97799 – "After careful consideration of the available information, the requested treatment has been authorized." PCID 1001022196

    b. July 11, 2013 – Procedure(s): 97799 – Certified Treatment: Chronic Pain Management 5x2 – Certified/Authorized. Start date 08-Jul-2013 - End date 07-Oct-2013. PCID 1001038136

    The Division finds the services in dispute were authorized. The requestor's position is supported.

3. 28 Texas Administrative Code §134.204(h)(1)(B) states, " If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR." Texas Administrative Code §134.204 (E) "Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

    (i) Program shall be billed and reimbursed using the "Unlisted physical medicine/rehabilitation service or procedure" CPT code with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

    (ii) Reimbursement shall be $125.00 per hour. Units of less than 1 hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

The services in dispute will be calculated as follows;

Date of Service	Submitted code	Billed amount	Number of units	MAR (125 x 80% x number of units)
May 20, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
May 22, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
May 23, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
May 29, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
May 30, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
June 3, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
June 4, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
June 5, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
June 6, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
June 17, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
July 23, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
July 24, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
July 25, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
July 29, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
July 30, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
July 31, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
August 1, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
August 2, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00

August 14, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
August 15, 2013	97799 CP	$1,000.00	8	$100 x 8 = $800.00
		$20,000.00	Total MAR	$16,000.00

4. The medical bill contained code 97750, FC – "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." 28 Texas Administrative Code §134.202 (e) states in pertinent part "Payment policies relating to coding, billing, and reporting for commission-specific codes, services, and programs are as follows: (4) Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the commission shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using the "Physical performance test or measurement..." CPT code with modifier "FC." FCEs shall be reimbursed in accordance with subsection (c)(1). Reimbursement shall be for up to a maximum of four hours for the initial test or for a commission ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements"

   A) A physical examination and neurological evaluation, which include the following:

      (i) appearance (observational and palpation);

      (ii) flexibility of the extremity joint or spinal region (usually observational);

      (iii) posture and deformities; (iv) vascular integrity; (v) neurological tests to detect sensory deficit;

      (vi) myotomal strength to detect gross motor deficit; and

      (vii) reflexes to detect neurological reflex symmetry.

   (B) A physical capacity evaluation of the injured area, which includes the following:

      (i) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and (ii) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative data base. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

   (C) Functional abilities tests, which include the following:

      (i) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);

      (ii) hand function tests which measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;

      (iii) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and

      (iv) static positional tolerance (observational determination of tolerance for sitting or standing).

   Review of the submitted documentation finds support for the services as billed. Reimbursement will be calculated per applicable rules and fee guidelines.

   - Procedure code 97750, service date May 8, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.45405. The practice expense (PE) RVU of 0.5 multiplied by the PE GPCI of 1.002 is 0.501. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.923 is 0.02769. The sum of 0.98274 is multiplied by the Division conversion factor of $55.30 for a MAR of $54.35. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $54.35. The PE reduced rate is $40.49 at 15 units is $607.35. The total is $661.70. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $592.00.

   The medical bill also contained code 90791 - "Psychiatric diagnostic evaluation." The carrier denied as185 – "The rendering provide is not eligible to perform the service billed." Review of the submitted documentation finds a referral from Dr. Stephen L. Esses for "Pain Management Eval & Treat". Review of the physician's profile indicates this physician's license does include psychiatry and neurology. The carrier's denial is not supported. The service in dispute will be reimbursed per applicable rules and fee guidelines.

- Procedure code 90791, service date May 3, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.8 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 2.8252. The practice expense (PE) RVU of 1.52 multiplied by the PE GPCI of 1.002 is 1.52304. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.923 is 0.10153. The sum of 4.44977 is multiplied by the Division conversion factor of $55.30 for a MAR of $246.07.

5. The total recommended payment for the services in dispute is $16,838.07. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $16,838.07. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $16,838.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $16,838.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		January 22, 2015
Signature	Medical Fee Dispute Resolution Officer	Date
		January 22, 2015
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.